Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2046AGZ	A. BUILDING _____ B. WING _____	C 05/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 E PRATER WAY SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 5/26/10 through 5/28/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 54 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 42. One resident file was reviewed. Complaint #NV00025429 was substantiated See Tag Y 515. The following deficiencies were identified:	Y 000		
Y 515 SS=G	449.259(1)(a) Supervision of Residents NAC 449.259 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary. This Regulation is not met as evidenced by: Based on record review and interviews from	Y 515		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 515	Continued From page 1 5/26/10 through 5/28/10, the facility failed to provide adequate protective supervision for 1 of 42 residents (Resident #1). Findings include: This facility is licensed to care for persons with Alzheimer's disease. On 4/14/10, Resident #1 was admitted to the facility with the diagnosis of Alzheimer's disease. She was placed in the facility for self neglect related to her disease while she was living independently. A Physician's Certificate of Needs Assessment conducted prior to her admission, revealed Resident #1 denied any disease but was severely limited in her mental capabilities. In the opinion of her physician, she was at severe risk for harm to herself and required 24 hour supervision. In addition, her son had been appointed as her guardian. In an interview, Employee #3 reported that on 5/24/10, when she heard the alarm at 8:40 PM, she opened the door and checked outside. Seeing no one, she came back inside and asked other staff members to check all resident rooms. Not finding Resident #1, Employee #3 conducted a more thorough search of the facility grounds while Employee #4 checked for the resident outside the building. In an interview, Employee #4 reported he noticed Resident #1 was not in her bed at 8:40 PM when he entered the room to collect items to shower Resident #1's roommate. Moments later, Employee #3 told him of the alarm sounding and asked him to check all resident rooms with the	Y 515		

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Y 515	Continued From page 2 other three staff for Resident #1. Employee #4 reported he then checked the outdoor area of the east wing of the facility and then the entire outer perimeter of the building. Later in the interview, Employee #3 reported that while she was searching the outdoor area, she discovered a lawn chair had been moved up against the 6 foot tall metal fence next to a tree. A later facility investigation found that Resident #1 had climbed the fence by using a lawn chair to climb up the limbs of a nearby tree to reach the top of the fence. According to the facility report, on 5/24/10, at 8:45 PM, facility administrative staff were notified as well as the police and Resident #1's family that the resident was missing. At 9:02 PM she was discovered by Employee #2 inside a pharmacy, trying to apply for a job. Resident #1's son, who lived nearby was interviewed by telephone. He stated Resident #1 had a history of wandering. He reported that he received a call from his cousin on 5/24/10, at approximately 9:00 PM. His cousin said he had been called by an employee of the pharmacy to find out where Resident #1 belonged. The son reported that he received the call from the facility several minutes later, informing him that Resident #1 had been found. Resident #1 crossed two four lane roads, after dark, with posted speed limits of 40 miles per hour, to walk to a pharmacy which was located .89 miles from the facility. Resident #1 was interviewed but denied any memory of climbing the fence and walking to the pharmacy at night.	Y 515		

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Y 515	Continued From page 3 The facility failed to provide protective supervision to Resident #1, who suffered from Alzheimer's disease, to ensure she did not wander unsupervised from the facility. Severity: 3 Scope: 1	Y 515		